PALLIATIVE CARE

IMPACT ON

QUALITY AND COST

BY JESSICA D. SQUAZZO
Palliative care is an emerging piece of the healthcare system that many predict will have a profound ability to improve quality of care, communication and coordination for seriously ill patients and their families and, through this process, reduce reliance on emergency departments and hospitals. Different in name and function than hospice and end-of-life care, palliative care is a unique, team-oriented approach to caring for the sickest of patients who are also, without doubt, the costliest.

Though not a new concept, it is perhaps one of the least understood service lines. It is, however, showing signs of growth, with the number of U.S. hospitals offering palliative care rising rapidly, according to the Center to Advance Palliative Care. Data from the Center and the American Hospital Association reveal that the number of programs in U.S. hospitals with 50 or more beds increased from 658 (24.5 percent) to 1,635 (66 percent) from 2000 to 2010—a 145.8 percent increase.

One person on the front lines of the emergence of palliative care programs in the U.S. healthcare system is Diane E. Meier, MD, FACP, director of the New York-based Center to Advance Palliative Care. “My mission is to improve access to palliative care across all settings,” Meier told the audience at the ACHE program “Palliative Care: Impact on Quality and Cost.” The program, funded in part by the Foundation of ACHE’s Fund for Innovation in Healthcare Leadership, was held Sept. 11, 2012, in conjunction with ACHE’s Atlanta Cluster Program.

During her keynote address, Meier, who is also vice chair of public policy and professor of geriatrics and palliative medicine and Catherine Gaisman Professor of Medical Ethics at Mount Sinai School of Medicine in New York City, made the case for why palliative care is so important to healthcare today and how organizations can begin to develop such programs.
According to Meier, it isn’t difficult to make the business case for establishing palliative care programs, especially at a time when, she said, the largest cause of bankruptcy in the U.S. is healthcare bills, and a very large portion of our population is underinsured.

“It is the costliest, very small proportion of patients that drive the vast majority of spending,” she said. “Healthcare spending is highly concentrated on the sickest and most vulnerable 5 percent of patients. Palliative care models have been shown to improve quality of life for these patients and families, to prolong life in a number of studies and, as a result, to enable patients to avoid the preventable crises and emergencies that land them in the hospital. The costliest patients are palliative care patients. That’s why palliative care is so critical to improving quality and reducing costs.”

**Defining Palliative Care**

Meier said one key way to help organizations think about palliative care and distinguish it from other service lines is to remember that, “Palliative care is not what we do when there’s nothing else to do.” Palliative care is delivered at the same time as appropriate disease-related therapies, she said. “You don’t move to hospice until disease-directed therapies are no longer working or their burdens begin to outweigh their benefits.” Palliative care differs from hospice or end-of-life care because the patients benefiting from palliative care programs aren’t necessarily dying. Often they are patients who are very sick but have a good prognosis and are expected to live. Most people with serious and complex chronic illness in the United States are not dying, but living with significant burden of illness for many years. Meier said the fact that there are pediatric palliative care programs operating at some organizations highlights the importance of not linking palliative care to end-of-life care. In Meier’s program at Mount Sinai, they are very accustomed to taking care of patients who are likely to be cured, such as bone marrow transplant patients, she said.

Meier shared the Center to Advance Palliative Care’s definition of palliative care with the audience. The definition was crafted using language that was most highly rated among the public, according to a public opinion survey conducted by the Center, so as to use language that is meaningful and important to patients and families:

“Palliative care is specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain and stress of a serious illness—whatever the diagnosis. The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses and other specialists who work with a patient’s other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment.”

As described in the above definition, palliative care is delivered by a care “team.” The team consists of key players such as physicians, nurses and advance practice nurses, social workers, chaplains or spiritual advisors, pain management specialists and others. The emphasis is on treating the patient’s medical condition but also helping him or her through the difficult practical challenges and emotional and spiritual distress that accompany a serious illness.

Patients’ family members and other loved ones also play a key part in palliative care. In a successful palliative care program, they are part of the conversation at the moment treatment begins. Palliative care programs also provide the proper counseling and support, including bereavement programs, if necessary, to patients’ loved ones.

Meier said the impact of serious illness on patients’ family members—including increased mortality and morbidity and post-traumatic stress disorder—cannot be ignored. “The cost to society from this is incalculable … [resulting in] people who can’t function as mothers, who can’t
go to work, who can’t return to their role in society,” she said. “That is a fault in the system we don’t think about much.”

Palliative care addresses three domains, said Meier. By addressing these domains, quality of care is improved and because patients feel better and remain in control, costs are reduced:

- Physical, emotional and spiritual distress
- Patient-family-professional communication about achievable goals for care and the decision making that follows
- Coordinated, communicated continuity of care and support for practical needs of both patients and families across settings

Evidence showcasing these and other benefits of palliative care programs is mounting, with hundreds of studies showing how palliative care can improve care quality, Meier said. A Harvard Medical School/Massachusetts General Hospital study published by the *New England Journal of Medicine* in 2010 found that in a randomized trial of patients receiving standard cancer care with palliative care co-management from the time of diagnosis versus a control group receiving standard cancer care only, the group receiving palliative care co-management experienced improved quality of life, reduced major depression, reduced “aggressiveness” in treatment (e.g., less chemotherapy before death, less likely to be hospitalized during the last month of care, etc.), and improved survival rates (11.6 months versus 8.9 months). Other studies have pointed to cost savings including reductions in use of costly imaging and pharmaceuticals and reductions in ED visits and time spent in the ICU.

**Making Palliative Care Work**

Meier provided attendees with an overview of what it takes in a healthcare organization to make palliative care succeed. At the top of the list is medical staff engagement. “If you don’t have respectful and strong relationships with front-line medical staff working with the patients and families, it won’t work,” Meier said. “A social worker alone can’t do it. Palliative care teams without a doctor are not going to work well.” Meier says having medical staff on the palliative care team is essential.

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**The Fund for Innovation in Healthcare Leadership**

The program “Palliative Care: Impact on Quality and Cost” was funded in part by the Fund for Innovation in Healthcare Leadership, a philanthropic initiative of the Foundation of the American College of Healthcare Executives (ACHE). An article on the first of two Fund programs for 2012, “The Ethics of Mission and Margin,” appeared in the September/October 2012 issue of *Healthcare Executive*.

The Fund was established in 2006 to bring innovation to the forefront of healthcare leadership by developing and enhancing its focus on future healthcare leaders, ethics in healthcare management and healthcare management innovations. In its commitment to developing future leaders, the Fund also has provided scholarships for the Foundation of ACHE’s Senior Executive and Executive Programs.

Since the Fund’s inception, more than 1,300 generous donors have made contributions. This support has enabled the Fund to strengthen the field of healthcare leadership by providing educational opportunities on important trends and issues.

For more information on the Fund, including ways to contribute, please visit [ache.org/Innovation](http://ache.org/Innovation) or contact Laura J. Wilkinson, CAE, vice president, Development, ACHE, at (312) 424-9305 or lwilkinson@ache.org.
care team provides added credibility to the information presented to patients and their families.

Other strategies for convincing physicians and others in the organization to get on board with palliative care include identifying opinion leaders in the organization and getting their interest and investment to help you sell the idea to others; interviewing others in the organization about what problems/issues they perceive and how they feel they should be addressed (this aids in relationship building); gathering quality data; focusing on quality; and, finally, seeking senior leadership’s support for a universal, systemwide palliative care screening checklist. “Palliative care is key to survival under a capitated, global budget,” said Meier. “When fee-for-service goes away and you’re not managing the sickest 5 percent in the best way possible, they will bankrupt your budget.”

After her keynote address, Meier introduced the program’s three panelists, who each discussed their organization’s experiences with palliative care.

**Advance Care Planning**

Bernard “Bud” Hammes, PhD, director, medical humanities, and director, Respecting Choices, at Gunderson Lutheran Health System in La Crosse, Wis., discussed advance care planning (ACP) as a complement to palliative care. He said the health system, which serves approximately 560,000 people in 19 counties in western Wisconsin, has invested heavily in the quality of the planning process—the process of knowing and honoring a patient’s informed plans.

Hammes outlined the three key desired outcomes of advance care planning:

- Creating an effective plan, including selecting a well-prepared healthcare agent or proxy when possible and creating specific instructions that reflect informed decisions geared toward a person’s state of health
- Having advance care plans available to the treating physician
- Incorporating the plans into medical decisions when and wherever needed

“Planning isn’t enough,” said Hammes. “We have to make sure these plans are available to the treating physicians, and they incorporate them correctly into decisions.”

Hammes discussed the relationship of ACP to advance directives. According to Hammes, the successful implementation of an advance directive is directly tied to the quality of the planning process or advance care planning. “If the process of planning has a poor quality to it, the plan will not work,” said Hammes. “Quality of communication with the patient and the family predicts the quality of the outcome.”

There are four key elements in designing an effective ACP program, according to Hammes. They are:
1. Systems design—build an infrastructure that assists in hardwiring excellence, including effective, standardized documentation, reliable medical records storage and retrieval, and an ACP team and referral mechanism. According to Hammes, advance care planning must be made routine among staff members and a part of the care process. “It has to be hardwired into how we relate to our patients,” he said. “No matter where patients are being treated, the written care plan must be available to the treating physicians.”

2. Advance care plan facilitation skills training—build confidence among staff and create an effective ACP team. Hammes said Gunderson Lutheran Health has experienced success with teams featuring “facilitators” who on behalf of doctors talk with patients about their values and goals in order to develop their care plans. Facilitators help take some of the burden off already-busy physicians.

Once the team is in place, staff training and use of a standardized curriculum are paramount. This ensures delivery of a consistent, reliable ACP service, according to Hammes.

3. Community education and engagement—reach out to communities with consistent messages about advance care planning. Because care in the La Crosse region involves two integrated health systems, all ACP-related materials distributed throughout the community have the names of both systems on them so patients know they can contact both systems related to their advance care plans, according to Hammes. This makes it possible to work effectively with all community groups and institutions.

4. Continuous quality improvement—measure and improve. Hammes noted the importance of continuously measuring your organization’s ACP program—and constantly looking for ways to improve it.

“One we didn’t create a successful system because we were persistent,” said Hammes. “We redesigned it and redesigned it until it worked.”

Making the Case for Palliative Care
Stacie T. Pinderhughes, MD, director of palliative medicine at Banner Good Samaritan Medical Center in Phoenix, told the audience about her experience with setting up a palliative care program at the system, which comprises 23 acute-care hospitals, when she began her job at the organization in 2010. She shared several important lessons learned.

One key lesson was to know your organization’s culture before you jump in. For Pinderhughes, she was fortunate to be at a hospital where “the doctors were very receptive and open to the whole concept of palliative care,” she said.

That buy-in from physicians is critical to the success of a palliative care program, according to Pinderhughes. But there was some education of physicians that had to be done, especially among the specialty groups such as hospitalists, primary care doctors and the hospital’s two large intensivist groups.

She recalled how it was helpful at Good Samaritan to have physicians round with the palliative care team to gain a better understanding of how a palliative care program works and see

Related Resources
American College of Healthcare Executives
“Strategic Integration of Palliative and Hospice Care: Implications for Health Systems, Physicians and Payors.” 2013 Congress on Healthcare Leadership session. Visit ache.org/Congress

Center to Advance Palliative Care
For tools and technical assistance for palliative care teams, visit www.capc.org. Information for patients, families and the general public may be found at www.getpalliativecare.org
the variety of services it offers. According to Pinderhughes, it also helped clinicians understand that palliative care is different from hospice care. “We made a deliberate decision at Banner Health System to debrand palliative care from hospice,” she said.

During year one of the palliative care program, the team consisted of Pinderhughes, a nurse practitioner and one social worker. Pinderhughes said bringing a social worker on board helped make connections in the community, an important aspect of palliative care.

Another key lesson Pinderhughes and her colleagues learned was the importance of getting C-suite buy-in. Showing senior leaders the cost benefit of a palliative care program is key.

“We found significant cost avoidance among these patients, which got the attention of the C-suite early,” recalled Pinderhughes. In the first year of its program, Good Samaritan’s palliative care team had seen approximately 500 patients. Since the program’s start, Pinderhughes said, the total cost avoidance attributed to Good Samaritan’s palliative care program is approximately $1.5 million.

At the end of the program’s first year, a Palliative Care System Developmental Initiative was convened and charged with developing a stable platform for the delivery of palliative care across the healthcare continuum. This group called together stakeholders across the system, including providers, risk management staff and administrators. The group began the process of defining palliative care for the system and developed a business plan, a plan for educating others about the program and an IT infrastructure for documentation. The palliative care team also defined the program’s mission and vision (and alignment with Banner Health’s overall mission and vision) and defined its patient population.

Pinderhughes recalled how crucial it was to have the CFO’s support with developing the business plan. Good Samaritan’s CFO was involved from the beginning, even accompanying the palliative care team on walk rounds. “Now he is an effective ally in the C-suite,” said Pinderhughes.

Pinderhughes said the team created tools to ensure palliative care at Good Samaritan was standardized. The team created an information card, which they distributed to physicians, residents, nurses, social workers and case managers. The organization’s EHR now includes a Palliative Care Rounding Tool in which palliative care team members document information. Palliative care information is also captured on the Palliative Medicine H&P (history and physical) Template the team developed.

Banner Health is now looking at developing palliative care programs in several of its hospitals and plans to work with its ACO to develop palliative care further across other settings. “We’ve laid the infrastructure, now we’re moving to the design phase,” Pinderhughes said.

**Buy-In From the C-suite**

When John M. Haupert, FACHE, became CEO of Grady Health System in Atlanta in 2011, one of his priorities was improving the way the system was managing the significant number of patients in need of hospice and palliative care. At least one-third of those patients were being improperly placed in the ICU.

As a safety net provider for Atlanta and one of the nation’s largest public...
hospitals with 625 acute-care beds, Grady’s payor mix is 30-30-20-20 (charity, Medicaid, Medicare, commercial). “To make this work economically takes a lot of work,” Haupert told the audience.

The development of Grady’s palliative care program is one major solution developed to help more efficiently and economically manage the most vulnerable among Grady’s patient population. Haupert and his staff established a vision statement for palliative care at the system, which “has become our calling card for everything we do, every action we take and every action we put our energy behind,” he said. The vision is inclusive and looks at the full continuum of palliative and hospice services. “We wanted to avoid a model consisting of just life-prolonging care,” Haupert said. An ideal model, he said, is a palliative care team working with hospice care staff and supportive services including after-care support.

The palliative care program at Grady is constantly evolving and improving as the organization learns what works best to serve its patient population. The focus is always on doing what’s best for patients and their families in difficult times. “We have a lot of work to do to treat people with the dignity they deserve,” Haupert said.

Grady’s palliative care program has been developed in three levels. The organization is currently working to get from level two to level three, and Haupert says they have identified the following factors that must be in place to make that happen:

- **Enhanced leadership**—including identifying clinical leaders
- **Established operational infrastructure**—including implementation of a palliative care service scorecard and deployment of resources to meet demand for services
- **Enhanced system integration**—including clinical partnerships with other service lines such as oncology and internal medicine

Haupert knows firsthand the importance of having C-suite buy-in for a palliative care initiative. “With my commitment, we will get there and make this happen,” he said.

Attendee Tammie Quest, MD, associate professor of emergency medicine and director, Emory Center for Palliative Care, which has a close working relationship with Grady Health, emphasized Haupert’s sentiment. It makes a difference in the success of a palliative care program when you work with senior leaders who are “incredibly motivated and enthusiastic,” she said.

“When you don’t have that from the C-suite, it’s really hard to take these programs to the next level.”

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